UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ALOXI (palonostron hcl)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Prevention of acute or delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy
- Must have failed on Zofran, Anzemet or Kytril (5-HT3's)
- No other 5-HT3 medications allowed as rescue drugs

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Repeat course of chemotherapy following initial 6 months requires new authorization

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